August 16, 2010

Via electronic comment filing system ECFS

Ms. Marlene Dortch
Office of the Secretary
Federal Communications Commission
445 12th Street SW
Washington, D.C. 20554

RE: In the Matter of Rural Health Care Support Mechanism WC Docket No. 02-60
FCC 10-125

Dear Ms. Dortch:

The Evangelical Lutheran Good Samaritan Society, The Society, is the nation?s largest not-for-profit senior care and services organization located in 240 communities within 24 states. We provide skilled nursing care, assisted living, housing with services, senior low income housing (HUD), specialty care units such as Alzheimer?s care, Home and Community Based Services, adult day care and more. We appreciate the opportunity to comment on your proposed rules.

V. Eligible Health Care Providers. D. Skilled Nursing Facilities. Section 123.
Quality health care for seniors in rural and frontier areas can be challenging due to distances, weather conditions health care shortages and more. Thanks to efforts by the Federal Communications Commission (FCC), the ability to create and enhance technology to improve health care is more realistic today. The Society strongly supports the proposal to allow non-profit skilled nursing facilities to be considered eligible for rural health care support under the category of ?not-for-profit hospitals? in applying for funds of the Universal Service Order of the National Broadband Plan. In many rural and frontier areas, a not-for-profit skilled nursing facility is the only source of health care for the community and area. Allowing funding for technology will help to improve health care of our seniors.

Sections 123, 124 and 125 speak to the conditions of eligibility for not-for-profit post-acute care providers (non-profit skilled nursing providers). These paragraphs seek to determine how these providers qualify for potential funding. We believe that attempting to use definitions of skilled nursing services and custodial nursing services to determine eligibility is not consistent with the rapidly changing health care environment. Hospitals and post acute providers must work very closely together to provide great care at the lowest possible cost. Not-for-profit skilled nursing facilities often provide this post acute care at the lowest cost due to cost reimbursement established by Congress or

the Centers for Medicare and Medicaid Services. Providing the same funding (no differentiation) along with other incentives will encourage providers to determine the appropriate health

care settings to deliver services. We believe these three sections should be simplified by providing the same level of support and eligibility criteria for not-for-profit skilled nursing facilities as not-for-profit hospitals. We believe there should be no differentiation in support as our health care environment continues to focus on the continuum of health services to be provided in all geographical settings, including rural settings.

V. Eligible Health Care Providers. D. Skilled Nursing Facilities. Section 125.
Please don?t make the financial award system complicated, based on numbers of Medicare residents. Post-acute census can vary greatly from facility to facility or even time of year. Section 125 of the proposed rules alludes to the fact of complications for eligible entities based on your current language. Simplicity will serve the Commission and rural not-for-profit skilled nursing facilities the best. You already have correctly identified that skilled nursing facilities are recognized providers of post-acute services in Section 124.

III. Health Infrastructure Program B.Provisions Applicable to Initial Application for Funding. 3. Funding Requests and Budgets. Section 30 Cap on Amount Funded Per Project.
We support the $15 million per project cap with the Commission retaining authority for a waiver on a case-by-case basis. We have approximately 240 skilled nursing facility locations in 24 states. We would hate to see a good and justifiable project eliminated from consideration because the allowed expenses exceeded $15 million for a particular location that could provide tremendous benefit to the rural residents of the not-for-profit skilled nursing facility. We want the Commission to have the flexibility it needs. We would expect almost all projects for a location will be under the $15 million amount and only those unique circumstances would exceed that amount.

III. Health Infrastructure Program B. Provisions Applicable to Initial Application for Funding, 3. Funding Requests and Budgets. Section 31 Cap on Number of Projects Per Year.
We oppose a cap on the number of projects and as stated in Section 30, we support a $15 million limit per project with waiver ability by the Commission. Rural areas of the United States need broadband capabilities and please do not limit the ability to provide numerous projects. Information provided to applicants could include information about your ?lessons learned? so that applicants are able to eliminate some of the problem areas you have seen applicants typically make.

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III. Health Infrastructure Program B. Provisions Applicable to Initial Application for Funding 5. Ineligible Costs. Section 42. Examples of Ineligible Costs. Electronic records management and expenses.
We urge you to consider electronic medical records as an eligible expense. One of the best ways to improve health care for rural residents, and for rural residents in skilled nursing facilities who are transferred to a rural or urban hospital is to ensure their medical records are electronically submitted from the skilled nursing facility to the hospital, and vice versa. Errors in prescription drugs, medical tests that have already be run and many other necessary pieces of information can be resolved if skilled nursing facilities also have electronic medical records. Stimulus funds have allowed $20 billion to doctors, hospitals and clinics for electronic medical records. Health reform legislation of this year will provide $400 million to for-profit and not-for-profit, urban and rural skilled nursing facilities. This addition to your rules, if an applicant?s funding project is approved, would greatly improve health care of seniors living in rural America.

III. Health Infrastructure Program C. Provisions Applicable After Initial Application. 1. Fifteen Percent Contribution Requirement, Section 45.
We encourage the Commission not to increase a higher level of participant contribution. We support the proposed 15 percent participation contribution.

III. Health Infrastructure Program C. Provisions Applicable After Initial Application. 3. Detailed Project Description, Section 53. Health IT Purposes.
We encourage you to include ?and other health technologies?, either in this section or in the National Broadband Plan. What you have listed now includes some clinical applications, such as e-care, telehealth and telemedicine but also non clinical items such as billing. Several other technologies are being used today that utilize broadband capabilities and the future will provide many different types that do not exist or are not defined as of today. The existing language limits the Commission to technologies that are common today but do not allow for advancement in the future. We believe having Commission flexibility is very important to rural health needs of not-for-profit skilled nursing facilities.

IV. Health Broadband Services Program, A. Eligible Services I. Recurring Costs, Section 93 and 97.
We agree with the noted expansion of the ?health broadband services program?. We strongly agree the first step for expanding the funding of broadband services should be focused on rural areas only. Therefore, it does not appear this proposed approach will impact section 254(h)(1)(A). As noted, rural health care is in crisis and available access to health care is at the center of the crisis. The

original intent of the legislation was rural health care and we do not believe that focus should change.

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We do not believe there should be a definition of a minimum level of broadband capability. Defining a minimum of broadband capability reduces the incentives of a provider to analyze and determine the minimum broadband services necessary to meet the access needs in providing health care services. There are techniques and design considerations that allow some providers to provide services successfully at less than four (4) Mbps. Many rural telecommunications providers can not provide 4 Mhps and some cannot even provide 1.54 Mbps of services. For these reasons, we believe that a definition of a minimal level of broadband capability is not necessary at this time and would prove to be counterproductive.

Conclusion

We sincerely appreciate what the Commission is proposing to accomplish to allow not-for-profit skilled nursing facilities the financial assistance to provide broadband technology, and the wonderful capabilities that means to improved health care in rural areas. We thank you for the opportunity to participate.

Sincerely,

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